Patient Information Form

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient Name_____Birthdate:_____

Address:_____City_____State_____Zip_____

Billing Address (if different)_____City_____State_____Zip_____

Cell Ph._____Home Ph._____Email_____

SS#_____Employer_____Work Ph._____

Spouse_____Emergency Ph._____

Dental Ins. Co._____ID#_____

Mailing address_____

Subscriber_____Birthdate_____SS#_____

Medical Doctor_____Date of last visit _____

Previous Dentist_____Date of last visit_____

Referred by_____

Dental Health History

Purpose of Initial visit_____

Have you had problems with previous dental treatment---------- Y N

Do you gag easily?---------- Y N

Do you wear dentures?---------- Y N

Does food catch between your teeth? ---------- Y N

Do you have difficulty chewing your food?---------- Y N

Does it hurt to chew or open wide?---------- Y N

Do you avoid brushing any part of your mouth due to pain?---------- Y N

Do your gums bleed easily? ---------- Y N

Do you chew gum or smoke a pipe?---------- Y N

Do your gums feel swollen or tender?---------- Y N

Do you take medications for pain or discomfort?---------- Y N

Are your teeth sensitive?---------- Y N

Are you aware of an uncomfortable bite?---------- Y N

Do you have pain in the face, cheeks, jaws, throat or temples?---------- Y N

How often do you brush?_____

How often do you floss?_____

Does your jaw make noises that bother you?---------- Y N

Do your gums bleed when you floss? ---------- Y N

Do you clench or grind your jaws?---------- Y N

Do your jaws feel tired?---------- Y N

Do you have earaches or pain in front of the ears?---------- Y N

Do you have jaw pain or headaches upon waking?---------- Y N

Does jaw pain affect your appetite, sleep, daily routine, or other activities?---------- Y N

Have you ever had slow-healing sores in or around your mouth?---------- Y N

Do you have Temporomandibular disorder (TMD)?---- Y N

Do you feel twinges of pain when your teeth come in contact with:

Hot foods or liquids?---------- Y N

Cold foods or liquids?---------- Y N

Sours or sweets?---------- Y N

Medical Health History

Do you have, or have you had, any of the following?

Heart Problems---------- Y N
Chest pain---------- Y N
Shortness of breath------- Y N
Blood pressure problem- Y N
Heart murmur---------- Y N
Heart valve problem------- Y N
Taking heart medication- Y N
Rheumatic fever---------- Y N
Pacemaker---------- Y N
Artificial heart valve------- Y N
Blood Problems---------- Y N
Easy bruising---------- Y N
Frequent nosebleeds----- Y N
Abnormal bleeding--------- Y N
Anemia---------- Y N
Ever require a transfusion Y N
Allergy Problems---------- Y N
Hay fever---------- Y N
Sinus problems---------- Y N
Skin rashes---------- Y N
Taking allergy medication Y N
Asthma---------- Y N
Intestinal Problems---------- Y N
Ulcers---------- Y N
Weight gain or loss-------- Y N
Constipation/Diarrhea----- Y N
Kidney or bladder problem Y N
Bone or Joint Problems---------- Y N
Arthritis---------- Y N
Back or neck pain---------- Y N
Joint replacement---------- Y N
Stroke(s)---------- Y N
Frequent or severe headaches--------- Y N
Thyroid problems---------- Y N
Premedications required by
physician---------- Y N
Are you allergic to any of the following:
Local anesthetics---------- Y N
Penicillin or other antibiotics---------- Y N
Sulfa drugs---------- Y N
Barbituates, sedatives or sleeping
Pills---------- Y N
Narcotics---------- Y N
Latex---------- Y N
Other_____

Diabetes---------- Y N
Urinate more than 6 times per day-- Y N
Thirsty or dry mouth often---------- Y N
Family history of diabetes---------- Y N
Tuberculosis or other respiratory disease---- Y N
Do you drink alcohol?---------- Y N
If so, how much?_____
Do you smoke?---------- Y N
If so, how much?_____
Hepatitis, jaundice, or liver trouble---------- Y N
Herpes or other STD---------- Y N
HIV-positive/AIDS---------- Y N
Glaucoma---------- Y N
Do you wear contact lenses?---------- Y N
History of head injury?---------- Y N
Epilepsy or other neurological disease?-------Y N
History of alcohol or drug abuse?---------- Y N
Do you have any disease, condition, or problem not listed that you feel we should know about?
If so, please describe:_____
During the past 12 months, have you taken any of the following?
Antibiotics or sulfa drugs---------- Y N
Anticoagulants (e.g., Coumadin)--- Y N
High blood pressure medication---- Y N
Insulin, Orinase, or similar drug----- Y N
Aspirin---------- Y N
Digitalis or drugs for heart trouble-- Y N
Steroids---------- Y N
Other_____
_____
Women:
Are you taking contraceptives or other
hormones?---------- Y N
Are you pregnant---------- Y N
If so, expected delivery date:_____

Patient Signature:_____